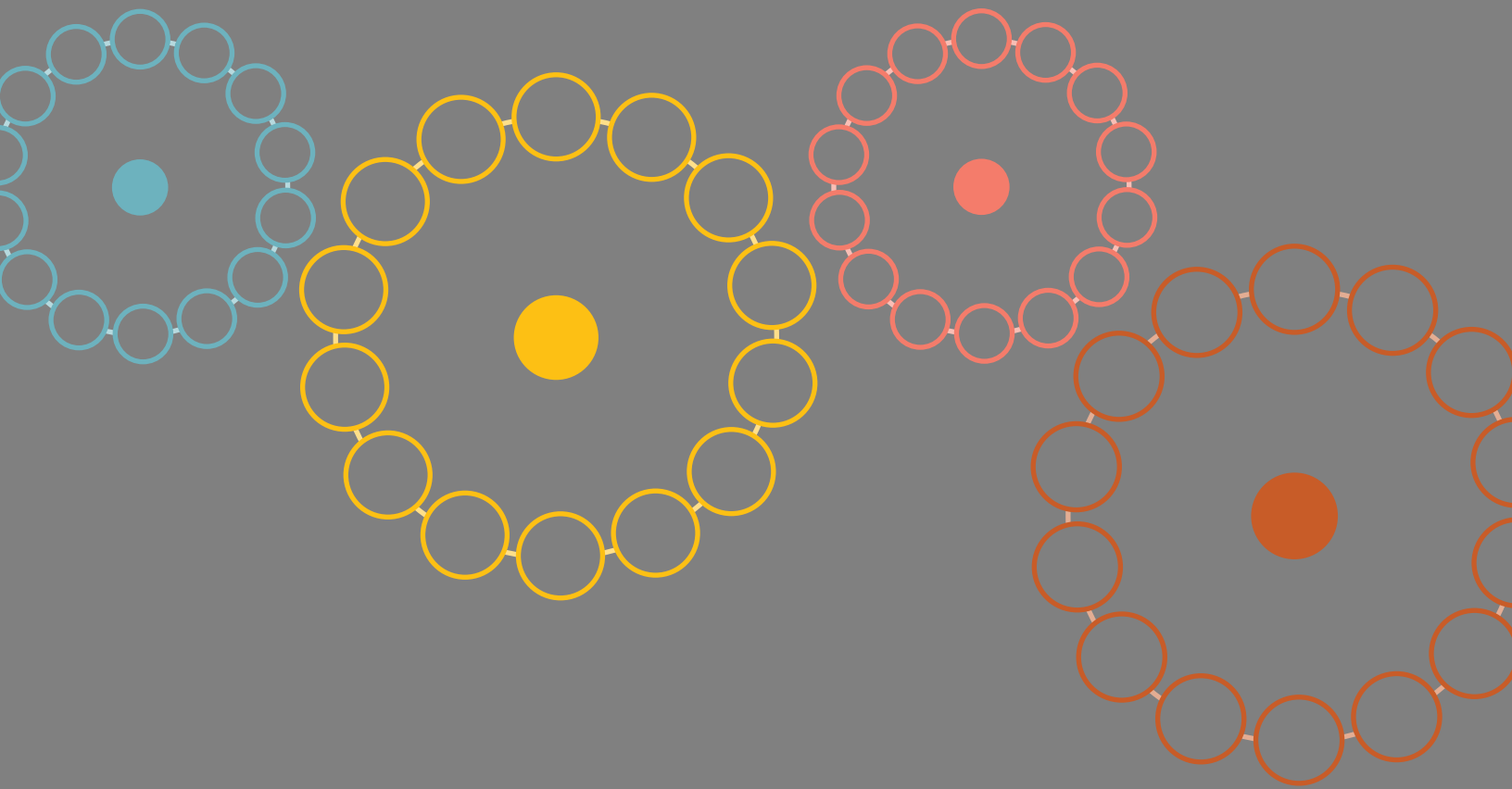


Elder Abuse Multidisciplinary Teams: **PLANNING** FOR THE **FUTURE**



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For well over a decade in places scattered across the country, professionals rooted in different disciplines and systems have banded together to handle complex cases of elder abuse. Known generically as “multidisciplinary teams” or “MDTs,” they range from professionals that meet voluntarily a few times a year to review cases to the action-oriented teams that took root in the 1990s and are now firmly established in the country’s landscape of social services.

Today there are elder abuse MDTs in large and small jurisdictions. The MDT model has been adapted to serve a variety of specialized purposes, generating teams that are expert in financial exploitation, for example, and those that review only tragic cases in which an older person dies as a result of abuse. While no longer a novelty, elder abuse MDTs are still far from becoming standard practice everywhere.

On September 8, 2014, elder justice experts and funders in the field gathered in New York City to reflect on the value of MDTs and discuss how to sustain and replicate them nationwide as part of a broader movement for elder justice. This publication captures key observations, questions and recommendations from that daylong symposium, supplemented with additional detail and background information. (See page 19 for information about the

host organizations and presenters.)

The issue could not be more urgent. Three recent large-scale studies found that between 7 and 10 percent of Americans age 60 and older experienced some type of abuse in the course of a single year, and many of them were victims of multiple forms of abuse.¹ As the population ages and absent more effective forms of prevention and intervention, more and more older Americans will become victims of abuse. In addition to their own individual suffering, society as a whole will pay the costs when elders who are beaten or neglected are treated in emergency rooms, admitted to hospitals, and in the wake of financial exploitation end up impoverished and on public assistance.

“I would argue that the hidden power and success of multidisciplinary teams is that they insist we constantly connect, in a real and deliberate way,” Joy Solomon, Esq,

said in her opening remarks as one of three hosts of the daylong discussion. She went on to explain that through the team structure, “we see each other, listen to each other, support each other, and recognize the goals and limitations of our agencies, and we are keenly aware of the real human being behind the complex case before us. It is the connection, the touching of agency to agency, that is the secret to the unmistakable impact of these teams.”

“I would argue that the hidden power and success of multidisciplinary teams is that they insist we constantly connect, in a real and deliberate way.”

—Joy Solomon, Esq

Readers less familiar with elder abuse MDTs will find enough basic information in these pages to appreciate the approach, while those with more experience can explore particularly challenging areas of practice, such as how to deal with ethical dilemmas that may arise in the course of a case and tackle what one symposium participant described as the “800-pound gorilla in the room”—the challenge of making a timely and accurate assessment of an older victim’s cognitive capacity and handling the case in a way that is appropriate to that individual’s abilities and limitations.

Reflecting some of the more spirited discussion during the symposium,

¹ See: Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The national elder mistreatment study. *American Journal of Public Health*, 100, 292; Laumann, E. O., Leitsch, S. A., & Waite, L. J. (2008). Elder mistreatment in the United States: Prevalence estimates from a nationally representative study. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 63(4), S248-S254; and Lifespan of Greater Rochester, Inc. (2011). *Under the radar: New York State elder abuse prevalence study*. Rochester, NY: Lifespan of Greater Rochester.

sium, this publication highlights four priorities for the field. Specifically, there's an urgent need for research on MDTs that defines success in terms of what older victims want and also generates the kind of cost-benefit analysis public and private funders increasingly demand. Equally important, evidence about the value of MDTs must be embedded in persuasive public messages about the need to protect the growing number of older adults from abuse. And finally, dedicated funding for MDTs coupled with technical assistance to guide the start-up of new teams and further refine practice are both essential. Greater investment in all four areas—research, advocacy, funding and capacity building—is necessary for this powerful response to elder abuse to move from being an exceptional practice to one that is routine in every community.

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A FEW FAQs ABOUT MDTs

Q. What is an elder abuse multidisciplinary team?

The defining feature of an elder abuse MDT is that it brings professionals from across disciplines and systems into the same room, at the same time, to problem solve together. Instead of touching only part of the elephant, so to speak, they see the whole. Whereas professionals working in isolation would be hampered by the limits of their own expertise and authority, as a team with a clear mission and guidelines they can address each case holistically, which leads to better outcomes for victims.

Q. Does the team get involved in every case of elder abuse?

No, only certain cases require the involvement of a team. MDTs typically focus on complex cases that require coordination among different systems and professionals. In these complex cases, the victim is often subject to multiple forms of abuse. Any team member can propose a case for review, and many teams also permit other organizations and individual professionals who are not regularly involved in the team to bring cases for discussion. The team's coordinator serves to triage cases, determining whether the case requires the team's services. (See "Skilled Coordination: The Essential Ingredient" on page 6 for more information about the role of the coordinator.)

Q. Are these cases really so complicated it takes a team of people to address them?

Yes, some cases can be. A single complex case might require different types of lawyers to handle both civil and criminal matters that range from taking action in housing court, to requesting an order of protection, to working with forensic accountants to unravel a history of abuse that involves extensive financial exploitation. The police might be involved in investigating the situation while the district attorney builds a case against the alleged perpetrator. A physician and mental health clinician might be called to evaluate and treat the victim and also provide evidence to the courts, while a social worker might be involved in addressing other urgent needs. If the victim's home remains unsafe, he or she will need temporary shelter and in some circumstances might have to relocate permanently. The municipal agency responsible for providing protection to vulnerable adults may need to monitor the situation, and the victim may require ongoing support from a community-based elder care agency. The team structure enables all these different individuals and the agencies they represent to work together effectively.

Q. Who are the members of the team?

While there's no must-have checklist of members, a team whose members are comprised of senior and experienced staff of the agencies and systems typically involved in complex cases of elder abuse will be stronger and more effective than a team whose members are drawn from only some of those agencies and systems or who lack authority within their agency or sufficient expertise. The participation of the local Adult Pro-

tection Services (APS) agency is especially important. In addition to regular members, a team may want to consult with other professionals that can shed light on a particular case given its circumstances. The illustration on the following page shows the members of a well-represented MDT.

"Whereas professionals working in isolation would be hampered by the limits of their own expertise and authority, as a team they can address each case holistically, which leads to better outcomes for victims."

—MDT Symposium attendee

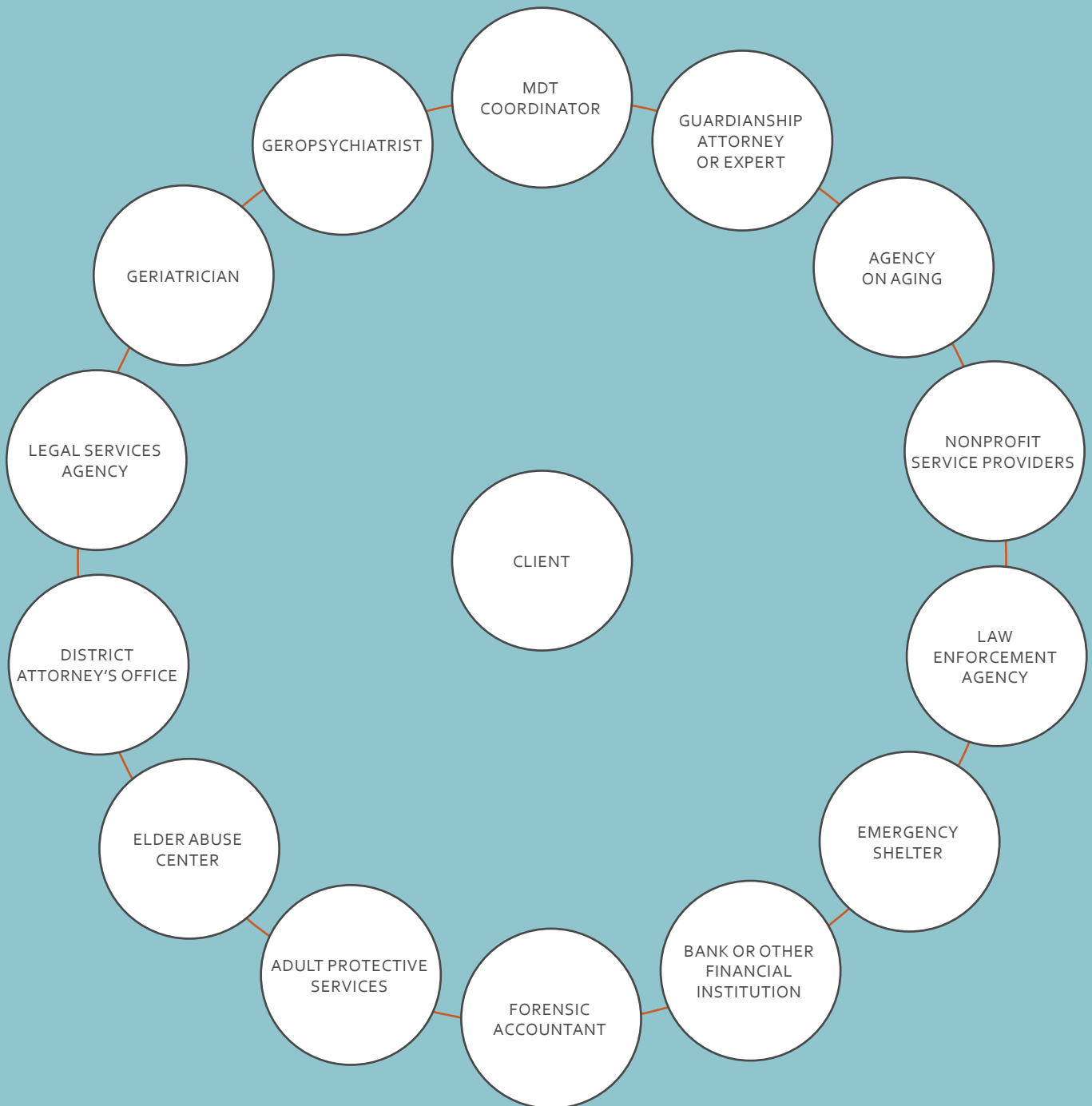
Q. What are some differences in the way MDTs operate?

There's actually considerable variety in how teams function. One important distinction is whether member participation in the team is mandatory or voluntary. While a voluntary structure can work, when individuals are mandated by the agency they work for to participate in an elder abuse MDT or paid for their participation, attendance at team meetings is likely to be more consistent and, as a result, team members can form stronger and more productive working relationships that make the team as a whole more effective.

The other important distinction is whether the team offers advice only to whomever presents the elder abuse case or actually takes coordinated steps to remedying the situation, monitoring the progress of the case and holding each other accountable for following through with

A SEAT AT THE TABLE: MEMBERS OF AN ELDER ABUSE MDT

Multidisciplinary teams are a powerful, person-centered approach to responding to elder abuse. They vary in terms of their membership. The graphic below illustrates the types of agency representation and individual participation on a strong team.



agreed upon assignments. Teams that have decision-making and accountability built into their mandate also typically make member participation mandatory and have a paid professional to coordinate the work of the team. Practice also varies in terms of how often teams meet, ranging from teams that convene weekly to those that meet bi-monthly or even quarterly. Teams that have some responsibility for managing cases tend to meet more frequently.

Q. Are confidentiality laws and standards a barrier to team work?

They don't have to be. Team members can discuss the circumstances of a case and detailed information about the victim and alleged perpetrator without knowing either person's identity—bringing their collective knowledge to bear on the case. At the same time, individual team members may have access to confidential information on a need-to-know basis and through the authority of their agency in order to take action to resolve the case. ♦

THE ALCHEMY OF A TEAM

The value of the MDT is more than the sum of each individual's expertise. When professionals with very different roles and responsibilities meet regularly to discuss complex cases of elder abuse, a kind of alchemy takes place that changes their perceptions and expectations of one another and of themselves—directly influencing what actions they recommend or take to resolve a case. That transformation takes place over time, through the hours and energy

people invest in the team.

In creating an MDT, the work initially involves convincing key agencies and individuals to participate. People with experience forming teams emphasize that getting buy-in hinges on conceptualizing the team as an asset—something that will help the members and the agencies they represent work more efficiently and produce better outcomes—rather than as added work. The team itself then fulfills that vision by providing a vehicle for members to learn from and support one another, both during team meetings and in the course of informal conversations that happen outside the scope of formal meetings.

Deborah Holt-Knight, Executive Director of Operations for Adult Protective Services in New York City, recalls that her staff, who were initially resistant to presenting cases at a newly formed MDT, have become more confident and skilled as a result of working with the team and are receiving recognition for the high quality of their casework. "I've seen incredible growth in our staff, and the agency overall has benefited because of the relationships we've formed through the MDT."

Jean Callahan, Esq, MSW, who is Director of the Brookdale Center for Healthy Aging at CUNY and serves on three MDTs in the New York metropolitan area, agrees: "You can really see how people up their game as they participate in more and more of these meetings." She also emphasizes that the team process mitigates the natural but counter-productive tendency people have in stressful situations to deflect responsibility and blame or criticize others. "It's hard to do that," Callahan says, "when you're

all sitting around the same table."

"I've seen incredible growth in our staff, and the agency overall has benefited because of the relationships we've formed through the MDT."

—Deborah Holt-Knight

"We become one another's allies and champions," Holt-Knight said. According to Solomon, those alliances mean that "we can set realistic goals and objectives when we ask each other to go back into the field or the courtroom, walk the beat, or consider new research questions."

Professionals who participate in MDTs are convinced this kind of teamwork leads to better outcomes for vulnerable victims of abuse. Risa Breckman, LCSW, the Director of the NYC Elder Abuse Center (NYCEAC) which oversees three MDTs, believes that, "It takes a village to do this work, and MDTs are villages for abused elders." Professionals like Breckman who have years of experience in the field of elder abuse can point to any number of specific cases to back up their beliefs. The description of teamwork in the case of Mrs. G on page 8 is just one example among many. ♦

SKILLED COORDINATION: THE ESSENTIAL INGREDIENT

Anyone with experience participating in an elder abuse MDT would agree that skilled coordination is essential.

At the most basic level, someone has to facilitate team meetings. In most teams, the coordinator is also the gatekeeper, deciding which cases merit review by the team, given the team's limited resources. And in teams that do more than review cases, the coordinator is responsible for monitoring the progress of each case and re-engaging the entire team or select members to ensure appropriate follow-up.

"People are vulnerable when they're presenting or discussing cases, and I help to create a supportive environment that facilitates teamwork."

—Robin Roberts, LCSW

Until recently, Robin Roberts, LCSW, served as NYCEAC's MDT Coordinator with oversight for their three elder abuse MDTs in NYC. In reflecting on her experience she said, "When a case comes in, I'm looking at all the issues involved to make sure that the right people are around the table when we meet. Every time I get a case, I need to look outside the box to figure out what's best. As soon as the meeting ends, people are given a checklist of what to do, what actions steps to take before the next meeting."

There's also an art to facilitating a collegial and positive team meeting, according to Roberts. "People are vulnerable when they're presenting or discussing cases, and I help to create a supportive environment that facilitates teamwork." As a neutral party, rather than a representative of

one of the agencies involved in the case, it was also easier for Roberts to mediate among team members—pointing out the benefits and limitations of each person's perspective, helping to resolve disagreements among members, and getting the team to reach consensus about the right path forward even in cases where the best possible outcome is less than ideal. While it's advantageous to have a neutral person as coordinator, it's certainly possible for a team member to fill this role.

Breckman said, "Coordinating and facilitating an MDT requires considerable skill, knowledge and maturity. You need someone who's an adept administrator and also has the credibility and acumen to work as an equal with an array of high-level professionals." ♦

THE BOTTOM LINE: UNDERSTANDING OPERATING COSTS

Because elder abuse MDTs leverage existing resources—most notably, skilled professionals who are already working in a municipality's network of public services—the hard costs of operating a team are relatively low. One participant in the symposium described MDTs as the "cheapest things out there," given their value. Participating agencies typically assign staff to the team without billing for their time, and one of the agencies typically provides meeting space free of charge.

"Despite the creative use of existing resources that characterizes MDTs, most teams need to raise money to cover at least some operating costs, and that continues to be a real challenge."

—MDT Symposium attendee

There are three areas, however, in which MDTs are more likely to require dedicated funding: pay for a coordinator who works full-time, part-time or on a consulting basis; consulting fees for specialists who serve as team members or provide advice in particular cases—typically geriatricians, neuropsychologists, psychiatrists and forensic accountants; and funds to create and manage a database system, which is especially important for teams that provide case coordination as opposed to just case review, and teams that are committed to monitoring and evaluating their work.

In some places, an MDT may be able to reduce operating costs in one or more of these areas of operation by sharing resources. For example, the three MDTs in New York City, operated under the umbrella of NYCEAC, share a paid coordinator, splitting the costs of a full-time employee among the three teams. The Westchester County MDT, just north of the city, pays a small fee to the Brookdale Center for Healthy Aging at CUNY so that the Center's Executive Director can serve as Coordinator of the team. Both approaches allow these teams to benefit from having a skilled and experienced professional in the key role of coordina-

tor. Public universities and medical schools often share faculty or staff with an elder abuse MDT in ways that significantly reduce operating costs. For example, the Director of the Elder Abuse Forensic Center in Orange County, California, is a fac-

ulty member at UC Irvine, and Weill Cornell Medical College's Division of Geriatrics and Palliative Medicine shares geriatricians with NYCEAC's three MDTs.

Despite the creative use of existing resources that characterizes MDTs,

most teams need to raise money to cover at least some operating costs, and that continues to be a real challenge. There is no dedicated funding for MDTs at the federal level, and few state departments of aging or human services earmark funds for

CASE STUDY: MRS. G

When Mrs. G, a 75-year-old widow, fell behind on her rent she decided to sublet the second bedroom in her apartment to an acquaintance of one of her neighbors—just for a few months until she was back on her feet. Although the man, a 40-year-old who worked nights at a near-by restaurant, agreed to a fee of \$150 a week, he never paid Mrs. G and yet refused to leave the apartment.

By the time this case was presented to the local elder abuse multidisciplinary team, Mrs. G had already experienced several increasingly abusive incidents. Whenever she had raised the issue of the unpaid rent, the man became angry and threatened her, so much so that she eventually sought advice from a social worker at a nearby organization for the aging. Mrs. G also told the social worker that some of her checks were missing and there were several mysterious charges to her credit card. Not long after, when Mrs. G walked in on the man rummaging through one of her handbags, he pushed her against the wall and punched her face. She managed to escape, running to a trusted neighbor, and was admitted to the hospital with a fractured jaw and a broken rib. Even more fearful than before, she initially told doctors that she had fallen but later, with the support of her social worker, agreed to file a police report.

Mrs. G's social worker understood that the case was complex and wanted guidance and assistance from the team. The immediate challenges were obvious: Mrs. G was in the hospital but would soon be released, and the man, who had been arrested, was also likely to be released within a day or two. Given these circumstances, lawyers on the team underscored the importance of securing a court order of protection to prohibit the man from returning to Mrs. G's home or contacting her, and also changing the locks on her front door for added

protection. They also recommended identifying a shelter for elder victims of abuse where Mrs. G could move temporarily, if the protective measures were not in place by the time she left the hospital.

To protect Mrs. G's assets, the lawyers recommended restricting access to her checking account, temporarily suspending her credit cards, and notifying the credit bureau about the unauthorized access to her financial accounts to protect her credit rating. They also told the social worker that Mrs. G would need help managing her finances, at least initially.

The team talked at length about whether or not to pursue a case against the perpetrator since Mrs. G was afraid he would retaliate against her. A representative from the prosecutor's office explained that her office would make clear to the defendant that the district attorney was proceeding despite the victim's own reluctance to press charges.

A geriatrician on the team underscored the importance of evaluating Mrs. G for possible sexual abuse, since verbal, physical and sexual abuse "tend to travel together." Having a complete picture of the abuse, the geriatrician further explained, is important to support healing and also to build a strong case against the perpetrator. On the subject of healing, a geropsychiatrist on the team called for Mrs. G to begin working with a counselor right away, rather than wait until she is released from the hospital.

And perhaps the most important message from the team: At this crisis moment, it's imperative that the social worker deepen her relationship with Mrs. G so that she can continue to be a strong advocate for her welfare in the difficult weeks ahead. Going forward, the social worker will take the lead in acting on the team's continued advice and recommendations.

this purpose—even in states that require localities to establish and rely on multidisciplinary teams in elder abuse cases. MDTs number among several unfunded mandates in the related fields of aging and elder abuse. Private funding from foundations or individual donors sometimes can be tapped to create an MDT, but unless government steps up to the plate to fund operating expenses over the long term, many teams cannot be sustained. The history of elder abuse MDTs is long enough at this point to look back and see that teams emerge and disappear as funds come and go.

To establish a steady source of funding for MDTs, the field needs studies that prove these teams are a wise investment and a plan to ensure that MDTs are part of a national agenda for elder justice. (For more information, see "The Future: Four Priorities for the Field" on page 14.) In particular, as advocates lobby Congress to fund the Elder Justice Act, money to develop, refine, and sustain MDTs should be among the key objectives. ◇

THE 800-POUND GORILLA: ASSESSING COGNITIVE CAPACITY

In a situation where elder abuse is suspected, knowing whether or not the alleged victim can appreciate the consequences of a particular action and make decisions in his or her own best interests is crucial. An assessment of cognitive capacity informs how professionals view the circum-

stances of a case and guides what actions they take in response. If a victim's cognitive capacity is significantly diminished, the State has authority to take actions on the person's behalf that it wouldn't have otherwise, even if the person refuses to cooperate—to remove the person from an unsafe home, for example, or appoint a legal guardian to make personal and/or financial decisions on the person's behalf. Steps like these and others might be necessary to protect the individual from further harm.

One participant in the symposium referred to the issue of cognitive capacity as the "800-pound gorilla in the room"—an allusion to its weightiness and also how challenging it can be to make this assessment in a timely and accurate fashion. While all elder care professionals understand the relevance of cognitive capacity, they don't always evaluate it in the same way or reach the same conclusions.

The law generally views capacity as task specific: Can an individual understand the nature and consequences of a particular decision, activity or event? Through this lens, it is possible for someone to have full capacity in one area of life but lack capacity in another. Prosecutors often rely on this understanding of capacity in building a strong case against an alleged abuser: Yes, Mr. M can manage daily tasks without assistance, but he has a poor grasp of his finances and didn't understand the consequences of "giving" that money to his niece.

Medical and mental health models, on the other hand, traditionally view cognitive capacity holistically, with an eye towards conditions and diagnoses, as opposed to evaluating discreet practical abilities—although

that is shifting. Going back to the example above, a physician might conclude that, overall, Mr. M has no significant cognitive deficits, an assessment that could lead Adult Protective Services to close the case, which in turn, could significantly undermine the prosecution efforts underway. To complicate matters even further, an older adult's capacity can be changeable, influenced by any number of external factors, such as medications, diet and hydration, time of day, and stress or trauma.

"While all elder care professionals understand the relevance of cognitive capacity, they don't always evaluate it in the same way or reach the same conclusions."

—MDT Symposium attendee

Having professionals from different disciplines working collaboratively in a team structure is a real asset in evaluating cognitive capacity and determining the best course of action. When one professional's view and recommended next steps conflicts with someone else's assessment, they can discuss it face-to-face with input from other team members and facilitation by the team coordinator. But many teams face an even more fundamental challenge: actually having complete and accurate information in hand to draw conclusions about capacity.

Professionals working in the field of elder abuse need reliable tools for evaluating cognitive capacity and protocols for using them. Nascent efforts to develop and validate such

tools are vitally important. Even with the aid of a valid assessment instrument, evaluations of cognitive capacity chronically lag behind other sources of information in overtaxed social service systems, which can leave a case either in limbo or potentially heading in a direction that isn't good for the victim.

Some experts believe that MDTs themselves need to be able to produce evaluations of cognitive capacity—either having one or more team members who may be paid to conduct evaluations or retaining consultants for this purpose. By controlling the process, a team can have access to this critical information when it's needed to make timely and wise decisions in a case. ◇

SUSTAINABILITY: HOW ORANGE COUNTY ESTABLISHED A LASTING MDT

We asked Laura Mosqueda, MD, founder of the Elder Abuse Forensic Center in Orange County, California, to describe the Center's origins and its evolution from novel idea to essential service.

When I arrived at UC Irvine in 1998, there was a countywide multidisciplinary team that met monthly. It was a large group, too large to be efficient, and they typically discussed just one or two cases of elder abuse at each meeting, providing only advice. I believed it was possible to hear more cases and actually take effective action to resolve cases. I started learning how Adult Protective Services (APS) actually works, and the head of the agency was very welcoming, even allowing me to shadow APS caseworkers on the job. Those explorations led me to form small medical response teams of doctors and psychologists that accompanied APS caseworkers on house calls.

With funding from the Archstone Foundation, we formalized that work in 2000 under the name VAST—Vulnerable Adult Specialist Team—and set up an office in one of the university buildings. We were ready for business, but our phone didn't ring. I remember feeling like we were the loneliest people in the world. We soon understood that we were too removed in our ivory tower and shifted our base of operation to APS.

We further evolved into an elder abuse forensic center in 2003 because we realized we were missing a crucial piece of the puzzle—law enforcement. It was the right move, but it meant accommodating more agencies and cultures into the team process. We brought everyone together to discuss why we needed to work as a comprehensive team.

I remember telling people something like, “I don’t want to add to your workload, I just want to make your job easier.” That meeting was crucial and a real turning point. We continued to operate out of APS headquarters, as the Center does today, because the agency provides space and is a convenient location for weekly team meetings.

I remember one of our first clear successes after establishing the Center. We learned about an elderly woman who was being kept in a motel room by her daughter. We went as a team, and it was the police officer members of the team that got us in the door. There was trash everywhere and an emaciated woman sitting in a chair. I was able to examine her on the spot and determined that she was not only malnourished but also demented. At the same time, the APS caseworker spoke to her daughter and realized that the daughter was mentally ill. The public guardian on the team acted swiftly to move the elderly woman into an assisted living facility. Her first meal was spaghetti, and she literally licked the plate clean. She ended up thriving there, and her daughter was referred to a local mental health agency.

“We brought everyone together to discuss why we needed to work as a comprehensive team. I remember telling people something like, ‘I don’t want to add to your workload, I just want to make your job easier.’ That meeting was crucial and a real turning point.”

—Laura Mosqueda, MD

Were we the first to do this kind of work? I don’t know. We weren’t aware of any other group working in this way and thought it was a novel idea. I think we were the first to plant the flag and call ourselves an Elder Abuse Forensic Center.

Having flexible funding from the Archstone Foundation was crucial to our development. It allowed us to experiment with different models and forge the relationships that are a requirement for sustain-

ing this kind of work. I can’t emphasize enough the importance of building trust and respect among team members. You have to know what you’re doing and respect what others are doing. It’s those relationships that provide the foundation for productive team meetings and the space for people to disagree and then move on. And you have to form equally solid relationships at a bureaucratic level—agency heads and other senior officials have to be committed. Sometimes we had to nurture their commitment. I remember, for example, giving special recognition to a particular police detective so that her superiors would support her participation on the team.

Perhaps most important, everyone has to be in it for the long term and be willing to accept and adapt when a key person leaves. We lost one agency for a whole year because they didn’t have the bandwidth at the time to replace the individual who left the team, but I stayed in contact with the agency head so that he knew what was going on and eventually they came back to the table. At this point in the Center’s life, no one panics when someone leaves. I left last year, and there was no doubt the Center would keep going. An enterprise like this can’t be dependent on any one person.

From the beginning we aimed to make ourselves invaluable. For several years, the county had been partially funding the Center, and in the fall of 2014 moved to fully fund the Center precisely because it provides a truly essential service.

Laura Mosqueda is Associate Dean of Primary Care and Chair and Professor of Family Medicine and Geriatrics at the Keck School of Medicine at USC (University of Southern California) and also Director of the National Center on Elder Abuse.

WHEN HELPING HURTS: CONFRONTING ETHICAL DILEMMAS IN CASEWORK

by Jean Callahan, Esq, MSW

Not long ago, one of the MDTs on which I serve was assembled around a table and listening as a caseworker described the circumstances of an 89-year-old victim of abuse. I'll call her Mrs. A to conceal her identity and thus protect the confidential nature of the information the caseworker was sharing. At the time of the meeting, she was living in the apartment she had occupied for many years. Mrs. A's 59-year-old son, who had been living with her for some time, was apparently abusing her.

Neighbors had reported hearing him screaming at his mother throughout the day and also suspected that he might be neglecting her basic needs. Thin and frail, Mrs. A uses a walker to get around and needs considerable assistance with her daily activities. There was also evidence that he was exploiting his mother financially—living off of her Social Security income and yet not paying the rent on their apartment for months. A teller at Mrs. A's bank recalled that the son brought his mother to the bank regularly to withdraw her monthly income and was loud and aggressive toward her while they were in the bank. The caseworker noted in particular that although Mrs. A appears fearful around her son, when asked about the situation, she always says that everything is

fine. And there was one other crucial piece of information: Mrs. A's son is mentally ill and financially dependent on his aging mother.

"An all-too-common and especially heartbreaking scenario is when the abuser is an adult child with mental illness or substance abuse issues. It's especially hard to know what to do in these cases."

—Jean Callahan, Esq, MSW

As a member of three multi-disciplinary teams in the New York Metropolitan Area, I hear many stories of elder abuse. An all-too-common and especially heartbreaking scenario is when the abuser is an adult child with mental illness or a substance abuse problem. It's especially hard to know what to do in these cases because both parties are in obvious need of assistance. Even if we limit our role to helping the elderly victim of abuse, what we actually do might prove hurtful to her.

In this case, to keep Mrs. A safe we took steps remove her son from their home. Although we involved a mental health agency that might be able to help him find housing and get the treatment he needs, assuming he is willing to cooperate, the outcome was not one that Mrs. A embraced. Despite her advanced age, frail condition, and the abuse she had endured, she still felt an obligation to care for her son at home. While counselors explained to Mrs. A that living with her son was seriously compromising her own health and

wellbeing, this may be one of those cases in which a simple happy ending is not possible. Many older people in similar situations report they continue to experience a different kind of suffering, one that's no less painful.

In situations like these, it is vital that the team recognize and discuss the ethical dilemmas at play: how to help the victim of abuse while minimizing the negative repercussions to a perpetrator who is also needy, and the difficulty of balancing the victim's safety with that person's right to make choices in life.

Jean Callahan, Esq, MSW, is Director of the Brookdale Center for Healthy Aging at City University of New York and a member of three MDTs in the New York metropolitan area. ♦

HOW ARE WE MEASURING SUCCESS?

Mark Lachs, MD, MPH, is a geriatrician with decades of experience in treating elder abuse victims, an epidemiologist, and renowned researcher in the elder justice field. We asked for his views on how to define and measure success in complex cases of elder abuse.

Q. You've been involved in reviewing complex cases of elder abuse for 25 years. What's your view of how to define success in an individual case?

ML: It really is highly dependent on the individual case, much the same as we now define success in geriatric medicine. Each patient presents a unique set of circumstances, problems and preferences, and as doctors we try to respond to their individual needs and wishes. Obviously, there are shared views about what constitutes dignity and safety for a victim of elder abuse, but beyond that, it is highly individualized. Some clients want the abuser removed from their environment as the only metric of success, others might like to see the abuser get help, perhaps treatment for a mental health condition. Yet others might want additional home care as a way to protect themselves from neglect.

Q. Do you believe MDTs are a good vehicle for achieving this kind of success?

ML: I've come to believe that a team is the only practical approach to meeting the individual needs of elder abuse victims. The factors that got victims into their predicament in the first place are wide ranging, and only multidisciplinary teams can address all of them.

Q. There's been very little research on the effectiveness of MDTs and virtually nothing that measures success based on what the victim wants. Why is that, in your opinion?

ML: Researchers are still slavishly devoted to the medical model of the randomized trial in which a single intervention is administered to a treatment group and the results are compared to a control group that received a placebo. That kind of research is virtually impossible in cases of elder abuse because victims are all different at baseline and treatments are all multi-component and delivered by different professionals. We need new methodological models to evaluate MDTs

and, for that matter, all elder abuse interventions.

Q. Are there examples from other fields to draw on?

ML: Many fields, including medicine and education, have developed client-specific metrics to measure success. Recently, with a colleague of mine in Toronto, Dr. David Burnes, I have become interested in goal attainment scaling as one possible way of evaluating elder abuse interventions, including MDTs. This method uses a standardized scale to measure a person's progress toward whatever outcomes are appropriate for that person, which is a very different approach than tracking how many people in a study achieve x or y as the positive outcome.

Q. What specific steps should the elder abuse field take to stimulate and secure funding for this kind of research?

ML: We need to attract smart young social scientists to our field and embrace new methodological approaches. Lousy research done in the infancy of the field still taints how people view the quality of elder abuse research. We also need to study the down-stream costs of elder abuse, in terms of hospital admissions, a host of other health care expenses, and much more to convince funders that this is not just an issue of individual suffering but that elder abuse costs society in many ways.

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THE FUTURE: FOUR PRIORITIES FOR THE FIELD

During the symposium, one of the hosts, Risa Breckman, LCSW, described the current landscape of MDTs as “pulsating.” “Some MDTs emerge as others fold,” she said, “because in large part, each team is on its own to find a way to sustain itself.” This image supports the current reality that elder abuse multidisciplinary teams are available in some places but not in many others, and that teams appear and fade away as funding comes and goes.

“The current MDT landscape is a pulsating one. Some MDTs emerge as others fold because in large part, each team is on its own to find a way to sustain itself.”

—Risa Breckman, LCSW

The need to spread this good practice throughout the country and sustain teams over time is a concern shared among participants in the symposium. In fact, one goal of the gathering was to begin to set an agenda for promoting replication and sustainability. Through facilitated working groups and other discussion during the daylong symposium, participants identified four priorities: research, advocacy, funding, and capacity building. While each of these is explored individually in some detail

below, it is the presence of all four elements reinforcing one another that is essential to spreading and sustaining MDTs as part of a broader movement for elder justice.

“Stakeholders in this field want MDTs,” Breckman said. As evidence, she pointed to the Elder Justice Roadmap, which surveyed hundreds of elder justice stakeholders in 2012, and called for “more MDTs across the country that have adequate support for facilitators and operations,” identifying the expansion of elder abuse MDTs as a “foundational priority.”²



1. Create a compelling body of evidence demonstrating the value of MDTs.

Multidisciplinary teams have existed for decades. Teams focused on elder abuse—the subject of this publication—were modeled on a prior generation of teams created initially in the 1950s to respond to child abuse. Despite the longevity of an interdisciplinary approach to casework, there is very little hard evidence of its impact. In the context of elder abuse, for example, research shows that

a collaborative response improves the effectiveness of individual agencies and is an efficient use of scarce resources, but findings like this fall short of revealing the ultimate value of a team approach.³

When asked to sum up the literature on multidisciplinary teams, Expert Consultant to the Department of Justice on Elder Abuse Sidney Stahl, PhD, sighed and admitted, “Unfortunately, there is no compelling body of research on whether or not multidisciplinary teams are effective in any context.” The absence of empirical evidence stands in stark contrast to the views of professionals who work as part of a team. In fact, the claim that “MDTs save lives” was included as part of the symposium’s Statement of Purpose.

Adria Navarro, PhD, LCSW, an Assistant Professor at Azusa Pacific University in California, is involved in what might be the most in-depth evaluation of an MDT to date. That research, which is still in progress, focuses on the Los Angeles County Elder Abuse Forensic Center. A comparison of “usual care,” Adult Protective Services (APS) clients with cases handled by the Center showed that the Center’s cases were 10 times more likely to be referred to the District Attorney for prosecution and also more likely to be referred for potential guardianship proceedings (called conservatorship in Los Angeles).

Moreover, at least by one measure, the Center produces longer-term benefits for both vulnerable elders and over-taxed public systems. The Center’s cases, which were more

² The Elder Justice Roadmap: A Stakeholder Initiative to Respond to an Emerging Health, Justice, Financial and Social Crisis. Report accessible at http://ncea.acl.gov/Library/Gov_Report/docs/EJRP_Roadmap.pdf

³ Wiglesworth, A, Mosqueda, L, Burnight, K et. al. Findings from an elder abuse forensics center. *The Gerontologist* 2006; 46:277-283.

complex and involved victims with a longer history of APS involvement, were less likely to return to the APS case rolls. Definitive cost-effective-ness outcomes are coming soon, but preliminary results suggest it is just a bit more expensive to produce these good outcomes. In framing the findings, Navarro is quick to also point out that the process underlying these positive results is both rigorous and highly valued by the professionals involved in it. Echoing so many other comments about MDTs expressed in the course of the symposium, she said, “It’s a really supportive environment.”

A federally funded evaluation of teams in New York State is also underway, with results expected in the next year or two. These kinds of studies are important steps in gathering the kind of evidence that public and private funders want before making a significant investment in elder abuse MDTs. In addition to more studies like these, symposium participants also called for research that is even more ambitious in both scale and type.

At the most fundamental level, there’s a need for a nationwide descriptive study—research that documents and describes the national landscape of MDTs through a survey that counts MDTs, describes their membership and operations, and explores what the professionals involved in these teams consider to be successful outcomes. Following that, a rigorous multi-site study would allow comparisons among different modes of operation and outcomes, revealing best practices and thus helping to refine practice nationally. Such a study could help the field understand, for example, if there are

must-have members for a team to be effective and the comparative value of teams that review cases versus teams that take action and are held accountable for outcomes—just two of several pressing questions. Research of this scale and depth is now possible because there are jurisdictions like Orange County, California, and entire states, such as Illinois, that have been operating elder abuse MDTs for well over a decade.

Equally important, several people talked about the need to define and measure success at least in part in terms of what a victim wants and views as a positive outcome. In other words: develop client-specific services and client-specific outcome measures rather than random control trials. Lachs, a leading geriatrician, believes this approach is essential, both from an ethical perspective and in terms of what’s practical. “If you’ve seen one elder abuse case, you’ve seen one elder abuse case. The population is immensely heterogeneous and so are the potential interventions.” Karl Pillemer, PhD, a renowned researcher in the field, agreed that new methodologies to evaluate elder abuse interventions are needed but offered that it would also be possible to evaluate MDTs using a random control trial. Right now, however, even a well-functioning MDT is drawing on a limited menu of programs and services. But with enhanced funding, Stahl pointed out, MDTs would be a “superb vehicle” for developing and testing new interventions. (For more information, see “How Are We Measuring Success?” on page 13.)

Finally, there was considerable talk about the need for big data and cost-benefit analysis that is

relevant and compelling nationally. MacArthur “Genius” Award recipient Marie-Therese Connolly, JD, took a lead role in that discussion. “The data is out there,” she said, referring to hospital admissions, nursing home admissions, public assistance, and a range of other costs that MDTs can prevent, “We just need to be smarter about how we do the math.”

As a concrete next step, participants suggested forming a research steering committee or consortium of organizations to take the lead in advancing this research agenda.

THE FUTURE OF MDTs: RESEARCH PRIORITIES

- » Nationwide descriptive study
- » Rigorous multi-site evaluation to identify best practices and related outcomes
- » Nationally relevant cost-benefit analysis
- » Victim-centered studies that evaluate success based on what victims view as positive outcomes
- » Formation of a national steering committee to advance these priorities

2. Become more vocal and persuasive advocates for MDTs as part of a broader movement for elder justice.

Scientific evidence of the benefits of elder abuse MDTs relative to their cost creates a foundation upon which to build a persuasive argument for establishing teams as the centerpiece of an effective approach to elder abuse. But evidence alone is not

enough to move the needle.

Advocates need to mine the experience of professionals who work as part of a team and the voices of victims and meld that with proof of a team's effectiveness to create messages that influence both policymakers and the public. As one symposium participant commented, the issue underlying it all is, how much does society value the life of a 94-year-old woman with dementia? There are important shared values—like the preciousness of life at any age—that need to be brought to public light and nurtured.

With the big picture in mind, several symposium participants questioned whether this successful approach to elder abuse needs a name that better captures what's at stake. One person suggested, for example, "Elder Abuse Action Team." Actually engaging in the kind of rebranding and associated messaging that would give MDTs the prominence they deserve was beyond the scope of a daylong meeting, but everyone in attendance seemed to agree that it is an area ripe for exploration, and that time is of the essence.

Congress passed the Elder Justice Act in 2010, but lawmakers have still not allocated funding to implement the Act. As advocates prepare to lobby Congress once again to provide the financing necessary to fulfill the promise of the Act, the role of multidisciplinary teams in the broader movement for elder justice must be part of the conversation and reflected in funding priorities—just as the Elder Justice Roadmap recommends. And while national-level advocates attempt to move the federal government, advocates at the local level must amplify their voices.

THE FUTURE OF MDTs: ADVOCACY PRIORITIES

- » Better messaging on the urgency of elder abuse, shared values that compel Americans to do more to protect older adults, and the value of MDTs
- » Possible rebranding of MDTs so that their meaning and significance is clear
- » Forming strong coalitions and leveraging existing mechanisms such as the Elder Justice Act and Roadmap
- » Advocating for change locally and nationally

3. Cultivate funding for MDTs to achieve sustainability.

Not surprisingly, everyone at the symposium lamented the lack of funding specifically for MDTs—funds to cover start-up costs and also to support ongoing operations. Mosqueda might have been the only person in the room who could say that the MDT she founded in Orange County, California, has full funding from local government and the promise of continued funding. (See "Sustainability: How Orange County Established a Lasting MDT" on page 10.)

Many teams struggle to raise annual operating costs, especially when foundation funding supported the creation of the team but won't support operations after the first few years. And given that the goal is to spread this good practice nationwide and sustain it, the gap in funding is so wide it will take federal dollars, state and local funds, and money from

foundations, corporations, and individual donors to fill it. Public-private partnerships seem to be especially fruitful terrain to explore.

"The gap in funding is so wide it will take federal dollars, state and local funds, and money from foundations, corporations, and individual donors to fill it."

—MDT Symposium attendee

At the moment, it can seem as if the field is caught in a kind of catch-22: Attracting funds depends in part on framing MDTs as a wise investment, but making that argument persuasively requires money up front to fund additional impact evaluations, risk reduction, cost savings and cost-benefit studies. Symposium participants agreed that the federal government and foundations must take the lead in supporting research. At least one such entity appears ready. Michael Marcus, a Program Director for The Harry and Jeanette Weinberg Foundation, made a commitment to support research and start-up costs for new MDTs and is calling on colleague funders in the field of elder justice to do the same.

In the meantime, those who seek to create and sustain MDTs need to make good use of the evidence they already have in hand—countless success stories—to appeal to a wide variety of potential funders. Peoples' voices and their stories are moving in ways that numbers are not. And storytelling is a good way to capture shared values and what we care about as a society.

THE FUTURE OF MDTs: FUNDING PRIORITIES

- » Up-front investment in MDTs by forward-thinking foundations, private philanthropists and government
- » Exploration of public-private partnerships, as well as non-traditional funding streams from institutions benefiting from MDTs, like hospitals and banks
- » Develop strategic message
- » Funding for impact evaluations, risk reduction, cost-benefit and cost savings studies to create the body of evidence that will open the gate to greater investment in MDTs

4. Provide resources and technical assistance to guide the start-up of MDTs nationally and refine practice.

Even if there was a pot of money to support the proliferation of elder abuse MDTs nationally, professionals at the local level don't necessarily have the know-how to form and operate an effective team. As one promising way to address the deficit in capacity, symposium participants suggested creating a National Resource Center on MDTs funded at least in part by the federal government.

One of the first things such a resource center would do is develop an MDT Start-Up Kit that would cover the full range of important decisions and procedures. Such a manual would address, for example, which

individuals and agencies to include in the team and how to decide the scope of a team's authority and obligations. It would provide sample policies and statements on, for example, sharing information while adhering to laws and standards on confidentiality, including the often-misinterpreted Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Kit also would provide guidance in particularly tricky or challenging areas of practice, such as assessing an individual's cognitive capacity and responding appropriately, managing common ethical dilemmas that arise in the course of a case, overcoming the barriers of working in a rural area where geriatricians and other specialists are scarce, and how to ensure that the team is handling a representative pool of complex cases and not only hearing cases brought by the most skilled and motivated caseworkers. As a complement to the Start-Up Kit, this new Center might provide draft legislation applicable at the state and county levels of government authorizing or mandating elder abuse MDTs.

Because the role of the team coordinator is so crucial, the Center could play a lead role in developing national standards and related training for coordinators and perhaps also a process for certifying coordinators. In this area of practice and others, the Center would function not only as a hub for the latest information about best practices and research findings but also as an engine for innovation—testing, for example, a SWAT-like model for use in emergency situations where a person's life is at risk and developing new modes of operating that reflect major shifts

in social service systems. As one participant said, "We can't assume that agencies will continue to operate in the way they do now."

In addition to the efficiencies associated with centralizing tools and expertise, the Center would encourage more uniform practice and outcomes around the country and would support the natural evolution of elder abuse multidisciplinary teams.

The National Resource Center on MDTs could be the go-to source for current best practices and the latest research, and also a hub of innovation to create the next generation of even better responses to elder abuse.



THE FUTURE OF MDTs: CAPACITY BUILDING PRIORITIES

Create a National Resource Center on MDTs that would:

- » Provide technical assistance
- » Produce an easy-to-use MDT Start-Up Kit featuring sample policies and protocols and guidance in handling especially challenging areas of practice
- » Develop national standards and related training for MDT coordinators and possibly also a process for certifying coordinators
- » Become the go-to source for best practices and the latest research as well as a hub of innovation

GOING FORWARD

In thinking about how to move these priorities forward, symposium participants noted the importance of tapping into existing projects like the Elder Justice Roadmap and the White House Conference on Aging to be held in 2015. Equally important is convincing influential national organizations and key decision-makers to become allies in this important work. As examples, participants named the National Adult Protective Services Association (NAPSA), the American Association of Retired Persons (AARP), state-level directors of departments of aging and other key government offices, legislators and foundations with a significant investment in aging and elder justice. Elder justice professionals should seek to galvanize grassroots advocates in this effort as well.

SYMPOSIUM PRESENTERS & FACILITATORS

"Elder Abuse Multidisciplinary Teams: Planning for the Future," a day-long symposium on September 8, 2014, was organized by the Brookdale Center for Healthy Aging at the City University of New York, the Harry and Jeanette Weinberg Center for Elder Abuse Prevention at the Hebrew Home at Riverdale, and the NYC Elder Abuse Center. The host organizations would like to recognize the following individuals who played a lead role in informing and facilitating the discussion:

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